MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04633 — 04632

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown RFD
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~Quak~~ Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RFD Chestertown, Md.
d. STREET ADDRESS: 1 RFD Quaker Neck
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ XX

3. NAME OF DECEASED (Type or print): First Mary — Middle Emma — Last Bass

4. DATE OF DEATH: Month 4/11/62 — Day — Year 19

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 3, 1876

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard Hodges

14. MOTHER'S MAIDEN NAME: Mary Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Pearl Smith - Chestertown, Md. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage(cause unknown — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
154 X
DUE TO: probable carcinoma of rectosigmoid)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ X

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/10, 1962, to 4/10, 1962, that (I) (we) last saw the deceased alive on 4/10, 1962 and that death occured at 1:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-12-62

22c. PHYSICIAN'S NAME (Type): Robert W. Farr

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/14/62

23c. NAME OF CEMETERY OR CREMATORY: Pomona Cemetery

23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wolfley

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE APR 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

APR 16 '62 Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04634

CERTIFICATE OF DEATH

04633

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Worton, Md.
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wilson Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RFD Worton, Md. (Coleman's)
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: W. — Last: Black

4. DATE OF DEATH: Month: Apr. — Day: 1, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1878

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Bus Owner

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Black

14. MOTHER'S MAIDEN NAME: Anna Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-12-2453

17. INFORMANT: Gough Dorsey — Address: RFD Worton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	chronic congestive heart failure	24 h
DUE TO (b)	acute pulmonary edema	36 h
DUE TO (c)	acute left ventricular failure	36 h

434.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(his hospital)~~ attended the deceased from 1955, 19..., to April 1, 1962 that (I) ~~(we)~~ last saw the deceased alive on March 31, 1962 and that death occured at 5 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Florence D. Joyce M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/1/62

22c. PHYSICIAN'S NAME (Type): Florence D. Joyce

22d. ADDRESS: RFD Worton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/5/62

23c. NAME OF CEMETERY OR CREMATORY: Coleman's Cem.

23d. LOCATION (City, town or county) (State): RFD Worton, Md. RFD

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wolfe

ADDRESS: Chestertown, Md.

25a. RECD BY REGISTRAR DATE: APR 6 62

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04635

CERTIFICATE OF DEATH

04634

Item 8 Film 6312 5/1/62 mb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia — Middle: — Last: Blake

4. DATE OF DEATH: Month: 4/21/62 — Day: — Year: 19

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2/10/1891 (1892)

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: domestic & other

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Blake

14. MOTHER'S MAIDEN NAME: Augusta Hynson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-16-9652

17. INFORMANT — Address: Walter Clarkson Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/16/62, 19..., to 4/21/62, 19..., that (I) (we) last saw the deceased alive on 4/20/62 19..., and that death occured at 3A.M. from the causes and on the date stated above.

22a. SIGNATURE: E Kester M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Eugene Kester

22d. ADDRESS: Rock Hall, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/23/62

23c. NAME OF CEMETERY OR CREMATORY: Sharptown, Cem.

23d. LOCATION (City, town or county) (State): near Rock Hall, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wolfe

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Timmes

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04636

CERTIFICATE OF DEATH

04635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): X Rock Hall
d. STREET ADDRESS: West Sharp Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Emily — Middle: Mary — Last: Bryden

4. **DATE OF DEATH**: Month: 4 — Day: 14 — Year: 19 62

5. SEX: Femald

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/25/10

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (County & State, or foreign country): Rock Hall, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewin S. Blackiston

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Freburger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 212-12-4775

17. INFORMANT — Address: S. Albert Bryden, Rock Hall, Md. (husband)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 year

199X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-1, 1962 to 4-14, 1962 that (I) (~~we~~) last saw the deceased alive on 4-14 1962, and that death occured at 9P M, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Keefe M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-15-62

22c. PHYSICIAN'S NAME (Type): A. T. KEEFE, JR. M.D

22d. ADDRESS: CHESTERTOWN, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/17/62

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

23d. LOCATION (City, town or county) (State): Rock Hall, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Marvin V. Williams, Chestertown, Md.

25a. REC'D BY REGISTRAR DATE APR 17 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04637 04636

Item 8 Film 6312 5/3/62 iwk

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena Rural
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Emory Middle: H. Last: Camp

4. DATE OF DEATH: Month: April Day: 23, Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: May, 24, 1885 (1885)

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Own Farm

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Emory H. Camp

14. MOTHER'S MAIDEN NAME: Sarah L. Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 215-36-8024

17. INFORMANT: Mrs. Elva H. Camp, Address: Galena, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion with massive myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 mn

420.1

DUE TO (b): Coronary artery disease — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 3, 19 62 to 23 Apr, 19 62, that (I) (we) last saw the deceased alive on 23 Apr 19 62, and that death occured at 6:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obemsbahin M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 24 Apr 62

22c. PHYSICIAN'S NAME (Type): Wallace Obemsbahin (Obenshain)

22d. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April, 26, 1962

23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery

23d. LOCATION (City, town or county) (State): Galena, Kent Co; Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows. ADDRESS: Millington, Md.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04638

CERTIFICATE OF DEATH

Reg. Dist. No. 04637

1 PLACE OF DEATH
a. COUNTY KENT MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL
c. LENGTH OF STAY IN 1b 5 YRS.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE New Jersey b COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALEM
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First NORMAN Middle JOB Last DENN
4. DATE OF DEATH Month APRIL Day 15 Year 1962

5 SEX MALE
6 COLOR OR RACE WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH NOV. 23 - 1891
9 AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) NEW JERSEY
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOB DENN
14. MOTHER'S MAIDEN NAME EMMA SEAGRAVES

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.I
16. SOCIAL SECURITY NO. 152-16-1013
INFORMANT MRS. VIRGINIA DENN Address ROCK HALL MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO (b) Cardio Vascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension, Arterio Sclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 14, 1962, to April 15, 1962 that I last saw the deceased alive on April 15, 1962, and that death occurred at 1:14 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Norbert C Nitsch M.D. ADDRESS (Street, city or town, state) ROCK-HALL- DATE SIGNED 4/16/62
PHYSICIAN'S NAME (Type) NORBERT-C-NITSCH-MD ROCK-HALL MD- 4/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF APRIL 17
22c. NAME OF CEMETERY OR CREMATORY East View
22d LOCATION (City, town, or county) Salem (State) N.J.

23 FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill, Md.
24a. REC'D BY REGISTRAR DATE APR 18 '62
24b. REGISTRAR'S SIGNATURE Clinton L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

Item 2 See birth cert

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04639

CERTIFICATE OF DEATH

04638

1. **PLACE OF DEATH** a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 1 hr 10/60 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KENT + QUEEN ANNE'S HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: PENNA. / MARYLAND / b. COUNTY: / KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN / PITTSBURGH
d. STREET ADDRESS: 151 McKnight Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: BABY — Middle: — Last: ESHMAN
4. **DATE OF DEATH**: Month: APRIL — Day: 20 — Year: 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 20, 1962
9. AGE (In years last birthday): ___ yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours 1 Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): KENT - MD.
12. CITIZEN OF WHAT COUNTRY? U.S. - Born

13. FATHER'S NAME: CHARLES EFFINGER ESHMAN JR.
14. MOTHER'S MAIDEN NAME: MARGARET GERTRUDE SCHEELER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: CHARLES F. ESHMAN JR. CHESTERTOWN MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): IMMATURITY (23 weeks gestation) 1 lb 7 oz - 650 gms
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 hr 10/60 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-20 1962 to 4-20 1962 that (I) (not) last saw the deceased alive on 4-20 1962 and that death occured at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: O. S. Gulbrandsen M.D.
ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): O. S. GULBRANDSEN, MD
22d. ADDRESS: CHESTERTOWN, MD.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/21-62
23c. NAME OF CEMETERY OR CREMATORY: St Paul
23d. LOCATION (City, town or county): Near Chestertown (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lamb
ADDRESS: Church Hill, Md.
25a. REG'D BY REGISTRAR DATE: APR 23 62
25b REGISTRAR'S SIGNATURE: Arthur B. Price

2-064094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Item 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04640

CERTIFICATE OF DEATH

04639

1. **PLACE OF DEATH**
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Chestertown
d. STREET ADDRESS: Calvert St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rebecca; Middle: ; Last: Frisby

4. DATE OF DEATH: Month: Apr. Day: 8, Year: 1962

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 14, 1881

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Queen Anne, Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Goldsboro

14. MOTHER'S MAIDEN NAME: Elizabeth Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give ware or dates of service): no

16. SOCIAL SECURITY NO.: nome

17. INFORMANT: Address: Fannie Wilson Cal. St. Chestertown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: one hour

DUE TO (b): Coronary arteriosclerosis — 7 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to 4/8 19 62, that (I) (we) last saw the deceased alive on 4/8 19 62 and that death occured at 10:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Lett Farr

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/ /1962

22c. PHYSICIAN'S NAME (Type): Robert W. Farr

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/62

23c. NAME OF CEMETERY OR CREMATORY: Janes Cemetery

23d. LOCATION (City, town or county): near Chestertown Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wolfe

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: APR 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04641

CERTIFICATE OF DEATH

04640

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Worton RFD Bigwoods

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Kent & Queen Anne Hospital

d STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ xx

3. NAME OF DECEASED (Type or print): First Vilda Middle Olivia Last Johnson (JOHNSON)

4. DATE OF DEATH: Month April Day 1 Year 1962

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/14/61

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months 4 & Days 17 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Johnson

14. MOTHER'S MAIDEN NAME: Helen Wilmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Helen Wilmer Johnson - Address: RFD Worton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 3-28, 1962, to 4-1, 1962, that (I) (we) last saw the deceased alive on 4-1 1962 and that death occurred at 8:00 A.M., from the causes and on the date stated above.

22a SIGNATURE: Robert W. Farr M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 4-1-62

22c PHYSICIAN'S NAME (Type): ROBERT W. FARR

22d. ADDRESS: Chestertown, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 4/3/62

23c NAME OF CEMETERY OR CREMATORY: Fountain Cem. RFD

23d LOCATION (City, town, or county) (State): Worton, Md. (Bigwoods)

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker

ADDRESS: Chestertown, Md.

25a REC'D BY REGISTRAR DATE Apr. '62

25b REGISTRAR'S SIGNATURE

1-025984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (see page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be delivered by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04642 **CERTIFICATE OF DEATH** 04641

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN Md: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD Fairlee

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairlee - Chestertown
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Howard Middle C. Last Jones, Sr.

4. DATE OF DEATH: Month Apr. Day 4 Year 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 4, 1885

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station owner & Operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry P. Jones

14. MOTHER'S MAIDEN NAME: Minnie Corey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO: 220-32-0496

17. INFORMANT: Maggie French Jones Address: RFD Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary artery disease-Coronary infarct — INTERVAL BETWEEN ONSET AND DEATH: 21/2 hrs.
DUE TO (b): Arteriosclerosis generalized — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-1 ..., 19 61, to April 4, 19 62, that (I) (we) last saw the deceased alive on March 24 19 62, and that death occured at 7 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/4/62

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/7/62

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cem.

23d. LOCATION (City, town or county) (State): near - Chestertown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: APR 9 '62

25b. REGISTRAR'S SIGNATURE: Catherine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04643 — Item 4 Film Cole 5/1/62 LWK — 04642

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Kentmore Park
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hackspoint
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Earl Middle Jerome Last Lewis

4. DATE OF DEATH: Month April Day 15 Year 19 62 (pronounced dead)

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1917

9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lt. Md. State Police

10b. KIND OF BUSINESS OR INDUSTRY: Police

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES M. LEWIS

14. MOTHER'S MAIDEN NAME: Flo[illegible] Windsor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO. 216-16-7139

17. INFORMANT: Tr. Cox, Md. State Police
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Drowning

DUE TO: Deceased went out fishing., his nets in the Sassafrass River near Kentmore Pk, Md. 4/1/62 about 3:53PM. It is known a blew up about 5PM. His empty boat was found that evening. All efforts of recovery of the body failed.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: short

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: His body was found floating in the river by Stansfield Wright of Earlville, Md. about 5PM 4/15/62.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): See above

20c. TIME OF INJURY: Hour about 5 p.m. Month, Day, Year 4/1 62

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): See above

20f. (City or town) nr. Kentmore Pk, (County) (State) Md.

MEDICAL CERTIFICATION

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

SIGNATURE Robert W. Farr M.D.

EXAMINER'S NAME (Type) Robert W. Farr, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED 4/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Apr 18 1962

22c. NAME OF CEMETERY OR ~~CREMATORY~~: Chesterquin

22d. LOCATION (City, town, or country) (State): Elkton, Maryland

23. FUNERAL DIRECTOR: [illegible] Sutton Bros Funeral Home

ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE APR 23 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04644 — **CERTIFICATE OF DEATH** — 04643

Item 8 Filmed 4/13/62 jwk

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1 2 Elm St

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9705 Belair Rd. (3X-2)
d. STREET ADDRESS: Balto, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susan — Middle: — Last: Luskow

4. DATE OF DEATH: Month: April — Day: 6 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Dec. 23. 1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam Weinbler
14. MOTHER'S MAIDEN NAME: Catherine Rohe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Elizabeth Enright — Address: 2822 Kennedy Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Thrombosis
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 days / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of the mandible Metastasis / Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Dec ....., 1960, to April 6, 1962, that (I) (~~we~~) last saw the deceased alive on April 6 1962, and that death occured at 6.30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Solow
22b. DATE SIGNED: April 7 1962
22c. PHYSICIAN'S NAME (Type):
M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-10-62
23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cem.
23d. LOCATION (City, town or county) (State): Balto, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Sarah Dent Home
ADDRESS: 7401 Belair Rd.

25a. REC'D BY REGISTRAR DATE: APR 10 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7.61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04645 — Reg. Dist. No. 04644

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Pondtown) RFD Millington
d. STREET ADDRESS: RFD #1 Box 71A Millington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Julius — Middle — Last Martin
4. DATE OF DEATH: Month Apr. — Day 29, — Year 1962
5. SEX: Male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 2, 1940
9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: various
11. BIRTHPLACE (State or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME: George Martin
14. MOTHER'S MAIDEN NAME: Daisy Cross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 217-42-5934
17. INFORMANT: Daisy Munroe — Address: Millington RFD Pondtown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Brain Damage as result of fractured skull — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Auto accident route # 290 Queen Anne Co
DUE TO (c): Md.
812X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Hit by auto while walking down road
20c. TIME OF INJURY: Hour 11:30 a.m. — Month, Day, Year 4/28/62
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): see above
20f. (City or town) RFD Crumpton, (County) Md. (State) Q.A. Co.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: C. R. Layton M.D.
EXAMINER'S NAME (Type): C. R. Layton,
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/29/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: A 5/1/62
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cem. near
22d. LOCATION (City, town, or county) Crumpton, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAY 1 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the execute this certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04645 (duplicate) 04645

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the hospital or attending physician.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Kent — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN Hospital: 15 hrs.40 min.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route 2, Chestertown — Lifetime
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Alverta — Middle: Tylden — Last: Nicholson

4. **DATE OF DEATH**: Month: 4 — Day: 13 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 2/24/83

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James L. Beck

14. MOTHER'S MAIDEN NAME: Alverta Brice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-36-1311

17. INFORMANT: J. Laurance Nicholson, Chestertown (son).

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (e), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	Coronary infarct	16 hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last — (b)	Coronary artery disease	3 years
DUE TO		
(c)	Arteriosclerosis	15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1957 to April 13, 1962, that (I) (we) last saw the deceased alive on April 13, 1962 and that death occured at 7:10 a.m. from the causes and on the date stated above.

22a. SIGNATURE: A.C. Dick M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 4-13-62

22c. PHYSICIAN'S NAME (Type): A.C. Dick, M.D.

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/15/62

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery

23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown, Maryland

25a. REC'D BY REGISTRAR DATE: APR 16 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Hynson

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04647

CERTIFICATE OF DEATH

04646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

72

I

1. PLACE OF DEATH
   a. COUNTY: Kent
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN this MARYLAND: 24 hrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall
   d. STREET ADDRESS: Rt. #1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: Mifflin; Last: Rochester

4. DATE OF DEATH: Month: 4; Day: 9; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/14/94 1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Vita Food

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clayton Rochester

14. MOTHER'S MAIDEN NAME: Louisa Banks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 216-14-9741

17. INFORMANT: Angeline J. Rochester, Rt. #1, Rock Hall, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 26 hrs.
- DUE TO (b): Arteriosclerosis
- DUE TO (c): Not known

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-8- 1962, to 4-9 1962, that (I) (we) last saw the deceased alive on 4-9 19 62, and that death occured at 4:30 a.m. p.m. from the causes and on the date stated above.

22a. SIGNATURE: A.C. Dick M.D.

22b. DATE SIGNED: 4-9-62

22c. PHYSICIAN'S NAME (Type): A.C. Dick, M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Chestertown, Kent, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/62

23c. NAME OF CEMETERY OR CREMATORY: Edesville Cemetery

23d. LOCATION (City, town or county) (State): near Rock Hall, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: APR 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04643

CERTIFICATE OF DEATH

04647

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Chestertown
c. LENGTH OF STAY IN this MARYLAND place: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at home (Quaker Neck)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Chestertown, Md.
d. STREET ADDRESS: Quaker Neck RFD
e. IS RESIDENCE ON A FARM? YES XX NO ☐

3. NAME OF DECEASED (Type or print): First Grace; Middle; Last Smith
4. DATE OF DEATH: Month Apr. Day 4, Year 1962
5. SEX: female
6. COLOR OR RACE: colored
7. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 31, 1903
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer & Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David S. Johnson
14. MOTHER'S MAIDEN NAME: Susie Walley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 215-20-0359
17. INFORMANT: Deitz Smith
Address: Chestertown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1 74 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
Carcinoma of Uterus
INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 19 62 to Apr. 4, 19 62, that (I) (we) last saw the deceased alive on 4/3/62 19 ..., and that death occured at 11 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Eugene Kester M.D
ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 6, 1962
22c. PHYSICIAN'S NAME (Type): Eugene Kester
22d. ADDRESS: Rock Hall, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 8, 1962
23c. NAME OF CEMETERY OR CREMATORY: Pomona Cem.
23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: APR 10 '62
25b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04649 — 04648

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: T.; Last: Tibbitt

4. DATE OF DEATH: Month: April; Day: 11; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February, 13, 1879

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming Retired.

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Tibbitt

14. MOTHER'S MAIDEN NAME: Annie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 218-05-8181

17. INFORMANT: Address: Charles H. Tibbitt, Son. Millington, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Chronic Myocarditis
DUE TO (c): Arterial Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 14, 1962 to April 13, 1962 that (I) (we) last saw the deceased alive on Feb 10, 1962 and that death occured at 4P M, from the causes and on the date stated above.

22a. SIGNATURE: C.H. Metcalfe M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): C.H. Metcalfe

22d. ADDRESS: Ruthrauff Inc

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April, 14, 1962

23c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery

23d. LOCATION (City, town or county) (State): Millington, Kent Co; Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows

ADDRESS: Millington Md.

25a. REC'D BY REGISTRAR DATE: APR 17 '62

25b. REGISTRAR'S SIGNATURE: Orlan L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04650

CERTIFICATE OF DEATH

04649

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Edesville) Rock Hall
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): At home Rural

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X (Edesville) Rock Hall
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Henry — Last Wesley

4. DATE OF DEATH: Month Apr. — Day 2, — Year 1962

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 15 1882

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboter

10b. KIND OF BUSINESS OR INDUSTRY: various

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Wesley

14. MOTHER'S MAIDEN NAME: Hester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Otho Wesley - Rock Hall, Md. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senility
DUE TO (b):
DUE TO (c):

794X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ↖ 1961, 19..... to 4/2/26, 19....., that (I) (we) last saw the deceased alive on 4/1/62 19....., and that death occured at 3 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Eugene Kester M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/2/62

22c. PHYSICIAN'S NAME (Type): Eugene Kester

22d. ADDRESS: Rock Hall, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/6/62

23c. NAME OF CEMETERY OR CREMATORY: Sharptown Cem. RFD

23d. LOCATION (City, town or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Bennett Dodd

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE APR 5 '62

25b. REGISTRAR'S SIGNATURE: Curtis L. Truax

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04651 — **CERTIFICATE OF DEATH** — 04650

Item 14 Film G312 4/30/62 iwk

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Worton
c. LENGTH OF STAY IN 1b: 28 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): -----

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural Worton
d. STREET ADDRESS: -----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Webster Last Younger
4. DATE OF DEATH: Month April Day 9, Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Kent, Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Daniel Younger
14. MOTHER'S MAIDEN NAME: Unknown Mary E. Coleman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: 214-32-6256
17. INFORMANT: Samuel Cullis Address: Worton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Carcinoma generalized — INTERVAL BETWEEN ONSET AND DEATH: 2 years

151 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of the stomach — ?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS ~~CONTRIBUTING TO DEATH~~ BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Basal cell Carcinoma of bridge of nose

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1960, to April 9, 1962, that (I) ~~(we)~~ last saw the deceased alive on April 1, 1962 and that death occured at 1:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Fr. H. D. Joyce M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-9-62
22c. PHYSICIAN'S NAME (Type): F. H. D. Joyce — 22d. ADDRESS: Worton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/12/62 — 23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery — 23d. LOCATION (City, town or county) (State): Worton, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: Still Pond, Md. — 25e. REC'D BY REGISTRAR DATE APR 12 '62 — 25b. REGISTRAR'S SIGNATURE: Clinton E. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be resumed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60